UNITED STATES CIVIL SERVICE COMMISSION
WASHINGTON 25, D. C.

October 6, 1959

DEPARTMENTAL CIRCULAR NO. 1024

TO HEADS OF DEPARTMENTS AND INDEPENDENT ESTABLISHMENTS

SUBJECT: Group Health Insurance: Implementation.

1. IN GENERAL

A. The benefit and contribution provisions of the Federal Employees Health Benefits Act of 1959 (Public Law 86-382, approved September 28, 1959), become effective on the first day of the first pay period which begins after July 1, 1960.

B. The Commission will move as rapidly as it can to negotiate contracts for and approve the health insurance plans which will participate in the Group Health Insurance Program. At the same time, regulations, agency instructions, forms, etc., will be developed.

C. It is expected that by about May 1, 1960, the Commission will make available to agencies the instructions, forms, and literature required to permit enrollment of employees and implementation of the program at agency and employing office levels. If in the meantime there are developments of interest or assistance to agencies, they will be publicized by supplements to this Departmental Circular.

2. INTERIM REFERENCE SOURCES

A. Until health insurance contracts have been negotiated and regulations and agency instructions have been formulated, no detailed information concerning the Health Insurance Program will be available.

B. The best interim reference source for agency use is Public Law 86-382 itself. Additionally, there is attached a series of Questions and Answers based primarily on Public Law 86-382. These may prove helpful in answering questions from employees. Agencies may duplicate and distribute all or any portions of these questions and answers.

3. BUDGET PLANNING FOR FISCAL YEAR 1961

A. Public Law 86-382 requires each agency to contribute toward the cost of its employees' health insurance coverage. These agency contributions will, generally, be paid from the appropriation or fund which is used for payment of salary, wages or other compensation of employees.

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B. For the purpose of planning budget requirements for fiscal year 1961, agencies may assume that the Commission will set the initial agency contribution per employee at the minimum amounts authorized by Public Law 86-382. These amounts depend on the type of enrollment and are as follows:

Type of Enrollment	Agency Contribution *
Self only	$1.30
Family	3.12
Family of female employee which includes nondependent husband	1.82

/Note: Employees will have a choice among expensive and inexpensive plans. Regardless of which they join, the agency contribution will be the same. The only exception to this will be the relatively infrequent case where an employee joins a plan the charge* for which is less than $6.24 per family enrollment or $2.60 per self-only enrollment. In this case the agency contribution will be 50% of the charge./

C. No reliable statistics are available to the Commission on the proportion of family to self-only enrollments. Unless an agency has a more reliable basis for determining this proportion, it may, for the first year of the program, assume that 60% of employees will enroll for family and 40% for self only. (No basis exists for even assuming the percentage of female employees who will enroll for a family which includes a nondependent husband.)

D. Item 3 of this Circular is issued with the concurrence of the Bureau of the Budget which will shortly issue supplemental instructions governing this item.

4. AGENCY RESPONSIBILITIES

A. At this early date, the Commission cannot say precisely what an agency's responsibilities under the Health Insurance Program will be except that, in general, they will probably be similar to those under the Group Life Insurance Program.

B. To assist agencies in gauging the initial program workloads in Personnel Offices and Pay Roll Offices, the Commission points out that every employee will have an unrestricted choice between at least two Government-wide plans and between two options within each of these plans. In many agencies employees will have an additional choice of enrolling in an employee-organization plan or in a group- or individual-practice plan. Each of these plans and options will probably require varying amounts of salary withholdings.

C. For the present, agencies are not required to take any action.

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* Biweekly. Convert to pay period basis for employees paid other than biweekly.

By direction of the Commission

Warren B. Irons
Executive Director

Attachment

QUESTIONS AND ANSWERS CONCERNING HEALTH BENEFITS FOR FEDERAL EMPLOYEES

ELIGIBILITY

Q. Who is eligible for health benefits?

A. Generally speaking, all employees who are eligible for Federal Employees' Group Life Insurance. (One exception to this rule is Tennessee Valley Authority employees; they already have their own health benefits program and cannot be included under this one.)

If you have the group life insurance, you will be eligible for the health benefits coverage.

Q. I do not have group life insurance because I signed a waiver of coverage. Can I get the health benefits?

A. Yes. The two are separate and not related to each other.

Q. Will the health benefits program be compulsory?

A. No. You do not have to apply for it if you do not wish to be covered.

Q. Will health benefits coverage be automatic or will it be necessary to fill out an application?

A. Coverage will not be automatic. Each employee who wishes to be covered will have to apply.

Q. Should I apply for the health benefits now?

A. No. The health benefits will not begin until the first pay period after June 30, 1960. Before that date, you will be given full information by your employing office and you will have plenty of time to apply.

Q. If I drop the health benefits coverage I now have, would my eligibility to join the Government-sponsored program next July be affected?

A. No. However, the safest thing is to continue your present health benefits plan until you come under the Government-sponsored program. In this way you will have continuous protection.

Q. Will the health benefits be only for myself or can my family be covered also?

A. You will be able to enroll for yourself only or for yourself and family.

Q. What members of a family may be included?

A. Your wife (or husband) and any unmarried children under the age of 19, including adopted children and also stepchildren if they live with you.

An unmarried child may be covered regardless of his or her age if he is incapable of self support because of a disability which began before he reached age 19.

Parents or other relatives cannot be covered even though they may live with you.

Q. Will I or any member of my family have to pass a physical examination to enroll for health benefits?

A. Not if you enroll at the first opportunity. If you enroll later, you may have to furnish evidence of good health.

Q. Can I (or a member of my family) be excluded from joining a plan because I have a hazardous job?

A. No.

Q. Can I be excluded from joining a plan because of my age?

A. Not if you enroll at the first opportunity. Employees and family members will be originally enrolled without regard to their ages.

Q. I am a Government employee and so is my husband. How do we enroll?

A. You may each enroll individually or one of you may enroll for the family. If you have children and one of you enrolls for the family, your children would also be covered. If you each enroll individually, your children would not be covered.

Q. My post of duty is outside the United States. May I enroll?

A. Yes. Even if the Government provides free medical facilities for you, you may wish to enroll in order to cover your wife and children if they are located in the States.

PLANS

Q. What kind of health benefits plans will be offered?

A. Every employee will have a choice between two types of Government-wide plans. One will be the service benefit type and the other will be the indemnity benefit type.

Many employees will have a further choice. Instead of joining one of the Government-wide plans, they will be able to enroll in an employee-organization plan or in a group-practice prepayment plan or in an individual-practice prepayment plan.

Q. What is the Government-wide service benefit plan?

A. This is one of the two Government-wide plans which any employee may join. It is a plan provided through Blue Cross-Blue Shield organizations and is similar to the kind of plan furnished by Group Hospitalization, Inc., and Medical Service of the District of Columbia. It is called a "service benefit plan" because it works on the principle of paying benefits directly to the doctor or the hospital which supplies the service to you.

Q. What is the Government-wide indemnity benefit plan?

A. This is the other Government-wide plan which any employee can join. It is the type of plan which is usually provided by commercial insurance companies.

It works on the principle of paying cash benefits directly to you--in other words, indemnifying you--although, usually, arrangements can be made for the plan to pay the hospital or doctor directly.

Q. What is an employee-organization plan?

A. There are several national employee organizations, such as the American Federation of Government Employees and the National Association of Letter Carriers, which sponsor health benefits plans for their members. The Civil Service Commission may approve such plans and any employee who is a member of an organization that sponsors a plan approved by the Civil Service Commission may enroll in the approved plan and get a Government contribution toward its cost.

Q. What is a group-practice prepayment plan?

A. There are a limited number of such plans. They operate only in certain areas, for example, the Group Health Association in Washington, D. C., the Health Insurance Plan in New York, and the Kaiser Foundation Health Plan in California. These plans have their own medical center or centers and their own doctors who practice as a group. If you live in an area where there is a group-practice prepayment plan and if it is approved by the Civil Service Commission, you may choose to join it instead of one of the other plans.

Q. What is an individual-practice prepayment plan?

A. This is a plan where doctors agree to accept regular payments from the plan instead of the usual charge to the patient. Like the group-practice plans, they operate only in certain areas. An example of these plans is the Group Health Insurance Plan in the New York City area. If you are in a locality which has such an approved plan, you may choose to join it instead of one of the other plans.

BENEFITS

Q. What benefits will each of the plans offer?

A. The law does not spell out the exact benefits for any of the plans so this question cannot be specifically answered at this time. The law does require each of the two Government-wide plans to offer the employee a choice or option between two levels of benefits.

The employee organization plans and the group- and individual-practice prepayment plans may or may not offer options between various levels of benefits.

Q. What will be the difference between the two options offered by each of the Government-wide plans?

A. There will be two main differences. First, one option will offer lesser benefits than the other and second, the option with lesser benefits will also cost less.

However, all options of the Government-wide plans will include both "basic health" and "catastrophic" coverage.

Q. What is meant by "basic health" coverage which each of the options under the Government-wide plans must include?

A. This is the kind of coverage most people now have. It gives some protection against the more common kinds of hospital and surgical expenses.

Q. What is meant by "catastrophic" coverage which each of the options under the Government-wide plans must include?

A. Catastrophic coverage gives some protection against the more unusual and heavy expense of a serious or prolonged illness. It often includes such costly items as long periods of hospitalization, expensive operations, private nurses, medical care received at home, drugs and medicines, medical supplies and equipment, etc.

Q. Will the employee-organization plans and the group- and individual-practice prepayment plans include catastrophic coverage?

A. Many of these plans may very well do so, but unlike the Government-wide plans, the law does not require them to include catastrophic coverage.

Q. What is the reason for having various plans and options?

A. There are two main reasons. First, it allows employees free choice of the kind of plan they prefer, for example, service benefits or indemnity benefits. Second, some employees may feel that they do not need as much protection and should not have to pay for coverage that they do not want. With the various plans and options you will be able to choose one which best fits your needs.

Q. How will I be able to decide which option or plan is best for me?

A. Before the law becomes effective, you will be given literature explaining the benefits of each plan and each option. You will then be able to select the plan or option you like best.

COST

Q. I have health benefits now. Will I be able to save any money if I enroll under the new law?

A. If you enroll in a plan or option with approximately the same benefits you now have, you would save money because the Government will be contributing part of the cost you now pay.

However, many employees will be able to enroll in a plan which offers much better benefits and will cost more than the plans they now have. But, because the Government will be contributing part of the extra cost, they will be paying approximately the same amount as they do now. Thus, such employees will be getting much better benefits at little or no additional cost to themselves.

Q. How much will the Government contribute toward the cost of my coverage?

A. Except in the situation explained in the next question, the Government will contribute not less than these specified amounts:

$2.80 a month if you enroll for yourself only;

$6.75 a month if you enroll for yourself and family.

/Note: The amounts mentioned here and in the next questions do not apply to a female employee who enrolls for self and family which includes a nondependent husband. If you are such a female employee, see later questions which apply to you./

Q. In what kind of situation would the Government contribute less than the $2.80 or $6.75 a month mentioned in the previous question?

A. If the total charge for the plan in which you enroll is less than twice the specified Government contribution--that is, if the charge is less than $5.60 or $13.50 a month--then the Government will contribute one-half the cost of your enrollment. For example: If you enroll for yourself and family in a plan the total cost of which is $10 a month, the Government would contribute $5 and you would contribute $5; if you enroll for yourself only in a $4 a month plan, the Government would contribute $2 and you would contribute $2.

Q. What will be the monthly charge of the various plans in which I will be able to enroll?

A. The exact charge for each plan will not be known until the specific benefits which each plan will offer have been agreed upon.

However, it is expected that at least one option in the two Government-wide plans will offer both basic health and "catastrophic" benefits at a total charge of about $13.50 a month for a family enrollment so that you will pay about $6.75 and the Government will pay $6.75. Similarly, at least one of these options will cost about $5.60 a month for a self-only enrollment so that you would contribute about $2.80 and the Government would contribute $2.80.

The other options of the Government-wide plans will offer greater benefits and therefore will cost more.

Q. Would the Government always contribute one-half the cost of the plan?

A. In many instances, as in the examples in the two previous questions, it would. However, if you enroll in a plan the total monthly cost of which is more than twice the specified Government contribution--that is, if the charge for the plan is more than, say, $5.60 for a self-only enrollment or $13.50 for a family enrollment, then the Government will still make its specified contribution and you will pay the difference. For example: If you enroll for yourself and family in a plan the total cost of which is $15.00 a month, the Government would make its specified contribution of $6.75 and you would contribute $8.25; if you enroll for yourself only in a $6.00 a month plan, the Government would contribute $2.80 and you would contribute $3.20.

Q. How much will the Government contribute for a female employee?

A. The Government's contribution for a female employee will be on exactly the same basis as for a male employee under the following conditions:

--If she enrolls for herself only.

--If she enrolls for herself and family and the family does not include a husband or does include a dependent husband.

Q. How much will the Government contribute for a female employee under a family enrollment which includes a husband who is not dependent?

A. In such a case the Government will contribute not less than $3.90 a month if the total charge for the family enrollment is $13.50 or more a month. The employee will contribute the difference between the $3.90 and the total charge.

If the female employee enrolls in a plan the total charge for which is less than $13.50 a month for the family enrollment, the Government will contribute 30% of the charge and the employee will contribute 70%.

Q. How will I contribute my share of the cost?

A. Through payroll deductions. Depending on how often you are paid, the proper percentage of the monthly charge will be withheld from your salary each pay period.

Q. Is there any guarantee that the cost of the plan in which I enroll will not increase?

A. No. Eventually the cost may increase because the plan may provide additional benefits or because the cost of paying for hospital and medical care may go up.

Q. Is there any maximum limit on the amount the Government can contribute?

A. Yes. The approximate maximum monthly amounts the Government can contribute are:

$3.95 for self-only enrollment;

$9.55 for a family enrollment;

$5.60 for a family enrollment which includes a nondependent husband.

However, it is expected that these limits will have no effect on the Government's contribution for a number of years and then only if the cost of a plan keeps going up to the point where the Government's contribution reaches these limits.

Q. Will I be able to continue my health benefits coverage after I retire?

A. Yes, if you meet certain requirements.

Q. What are the requirements I must meet?

A. There are five requirements, all of which you must meet. They are as follows:

1. You must retire under the Civil Service Retirement System or some other system for civilian employees of the Federal or District of Columbia Government.

2. You must retire after the date the health benefits program became effective in your employing office--that is, after the first day of your first pay period which began on or after July 1, 1960.

3. When you retire, you must have been enrolled in an approved plan for at least the shorter of the following two periods of time:

   (a) the five years of service immediately before your retirement

   or

   (b) all your service between the time you first had the opportunity to enroll and the time you retire.

4. You must retire after at least 12 years of service or on account of disability. (The 12 years of service can include military service, but must include at least 5 years of civilian service.)

5. You must retire on an immediate annuity--that is, the beginning date of your annuity must be not later than one month after your separation from service.

Q. If I should die, would my wife (or husband) and children be able to continue the health benefits coverage?

A. Yes, if they meet certain requirements.

Q. What are the requirements they must meet?

A. There are two requirements:

1. At the time of death, you must have been enrolled for yourself and family and have completed 5 years of civilian service.

2. Your wife (or husband) and children must be eligible to receive a survivor annuity from your retirement system.

Q. If an employee- or survivor-annuitant continues the health benefits coverage, does he have to pay for it?

A. Yes. However, he does not have to pay more than an employee who is enrolled in the same plan.

Q. Will the Government contribute to the cost of an annuitant's enrollment?

A. Yes--on the same basis as to an employee's.

Q. How will an annuitant pay his portion of the enrollment cost?

A. It will be withheld from his monthly annuity.

Q. Will an annuitant be entitled to the same benefits as an employee?

A. Yes. All plans will provide the same benefits for annuitants as they do for employees.

MISCELLANEOUS

Q. If I enroll in one plan, will I later be able to transfer to another plan?

A. Yes, under certain conditions which will be determined later.

Q. If I enroll for myself only, will I later be able to change to a family enrollment?

A. Yes. You will also be able to change from a family enrollment to a self-only enrollment.

Q. If I should leave Federal employment, will I be able to keep my coverage?

A. Yes. You will be able to convert your group coverage to individual coverage. Of course, the Government will not contribute any longer and you will have to pay the total cost of the coverage yourself.

Q. If I go on leave without pay, will I be able to continue my coverage?

A. Yes, for up to one year, under certain conditions to be determined later.

Q. If I enroll in a plan, will I be given a certificate?

A. Yes, you will be given a certificate or other document which will summarize the benefits to which you are entitled and how to apply for them.

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Will we?